

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

RITA CZYZEWSKI,

Plaintiff,

v.

COMMISSIONER OF SOCIAL
SECURITY,

Defendant.

HONORABLE JEROME B. SIMANDLE

Civil No. 14-7255 (JBS)

OPINION

APPEARANCES:

Lauren S. Tovinsky, Esq.
JACOBS SCHWALBE & PETRUZELLI PC
10 Melrose Avenue, Suite 340
Cherry Hill, NJ 08003
Attorney for Plaintiff Rita Czyzewski

Paul J. Fishman
UNITED STATES ATTORNEY
By: Andrew Charles Lynch
Special Assistant U.S. Attorney
Social Security Administration
Office of the General Counsel
300 Spring Garden Street, 6th Floor
Philadelphia, PA 19123
Attorneys for Defendant Commissioner of Social Security

SIMANDLE, Chief Judge:

I. INTRODUCTION

This matter comes before the Court pursuant to 42 U.S.C. § 405(g) for review of the final decision of the Commissioner of the Social Security Administration denying Plaintiff Rita Czyzewski's application for disability insurance benefits under

Title II of the Social Security Act, 42 U.S.C. § 401, et seq. (the "Act").

Plaintiff principally argues that the Administrative Law Judge ("ALJ") failed to properly evaluate and weigh the opinion of the agency consulting physician, Dr. Joan Joynson. Specifically, Plaintiff contends that the ALJ erred in failing to adequately address that Dr. Joynson initially identified Plaintiff's mental impairments as severe, but later changed her opinion of these impairments to non-severe upon the request of an agency reviewer. Plaintiff also argues that the ALJ's finding regarding her residual functional capacity is not supported by substantial evidence because the ALJ did not account for her anxiety, depression, and fibromyalgia. Plaintiff also argues that the ALJ improperly discounted Plaintiff's testimony regarding her limitations. Plaintiff maintains that the record is fully developed and ripe for a decision in her favor without remand.

For the reasons discussed below, the Court rejects Plaintiff's arguments and will affirm the ALJ's decision.

II. BACKGROUND

A. Procedural History

Plaintiff filed an application for disability insurance benefits on October 24, 2011, alleging an onset of disability on

July 9, 2010. (R. at 18.) The claim was denied, as was a request for reconsideration. (Id.) Plaintiff appeared at a hearing held on January 17, 2014 before the ALJ, Marguerite Toland. (Id.) Plaintiff was represented by an attorney and elected to give testimony. (Id.) On March 25, 2014, the ALJ denied Plaintiff's appeal at step five of the sequential analysis, finding that Plaintiff was capable of performing past relevant work as a medical secretary. (R. at 29.) The Appeals Council denied Plaintiff's request for review. (R. at 1-6.) Plaintiff then filed the instant action.

B. Medical History

The Court finds the following facts relevant to the present motion. Plaintiff was 59 years-old as of the hearing date, and she had past work experience as a medical secretary. Plaintiff's medical history includes treatment for fibromyalgia, high blood pressure, carpal tunnel syndrome, anxiety, and depression. Plaintiff noted in her testimony that she did not receive continuous treatment for her various medical conditions because she lacked health insurance since leaving her job in November, 2010. (R. at 46.)

1. Kennedy Health System

Plaintiff sought emergency medical attention for anxiety and panic attacks in August, 2002. (R. at 335-44.) Plaintiff

reported severe anxiety over the preceding six weeks, as well as repeated visits to the emergency room for panic attacks. (R. at 339.) She was discharged with a diagnosis of generalized anxiety disorder and prescribed Klonopin, Zoloft, Depakote, and Seroquel. (R. at 339-44.) Plaintiff was to follow up with Dr. Talati. (R. at 339.) The Court is unable to locate any other reference to Dr. Talati in the record, and it is therefore unclear whether Plaintiff received follow-up mental health care as directed.

2. Virtua Family Medicine

On January 13, 2011, Plaintiff was seen at Virtua Family Medicine for abnormal blood pressure and anxiety. (R. at 284.) Plaintiff indicated that she felt like her anxiety was returning. (Id.) Notes from this visit query whether Plaintiff's blood pressure issues were causing her anxiety or vice versa. (Id.) There are no subsequent notes from this facility in the record.

3. Virtua Health Emergency Room

On May 5, 2011, Plaintiff presented at the emergency room with reports of chest pain and diaphoresis which "resolved spontaneously." (R. at 287.) Upon physical exam, emergency room doctors reported no abnormal cardiac findings. (R. at 288.) Plaintiff's EKG was normal. (Id.) Imaging revealed no active

disease in the chest, no evidence of ischemia or infarction, and normal left ventricular chamber size and wall motion. (R. at 306-07.)

4. Dr. Ferenz

On August 22, 2011, Plaintiff saw Dr. Clint C. Ferenz, M.D., for an evaluation of her right hand. (R. at 313-16.) Plaintiff reported chronic pain in both hands, as well tingling and numbness in her right hand. (R. at 313.) Plaintiff noted increased pain in her hands since she stopped working in November, 2010. (Id.) Plaintiff previously had not sought treatment for the problem. (Id.) Dr. Ferenz attributed Plaintiff's bilateral hand pain to early degenerative arthritis and noted the possibility of right carpal tunnel syndrome. (R. at 314.) Dr. Ferenz recommended follow-up treatment including bracing, nerve study, and possible surgery if right carpal tunnel syndrome is confirmed. (Id.) However, Dr. Ferenz concluded that Plaintiff's complaints "would not inhibit her ability to work at full duty status." (R. at 315.)

5. Dr. Goldberg

Plaintiff was examined by Dr. Kenneth Goldberg, Ph.D., on January 17, 2012 as part of a consultative mental status exam. (R. at 317-321.) Plaintiff described a history of panic attacks and general feelings of anxiety. (R. at 318.) Plaintiff

explained that she had not experienced a panic attack recently and that they only occur "once in a blue moon." (Id.) Plaintiff reported that when she was working she would experience panic attacks as frequently as three times per day, but noticed that the attacks had diminished as she got older. (Id.) Because Plaintiff tended to experience panic attacks when she was alone, she seeks the company of people. (Id.) Plaintiff reported a similar decrease in her symptoms of depression as time passed. (Id.) She described herself as more often happy than depressed, said she does not get tearful as she did in the past, and noted that her periods of depression tend to be short and associated with lack of sleep. (Id.)

Dr. Goldberg's report indicates that Plaintiff drove to the appointment; that Plaintiff can perform ordinary household tasks; and that she can shop. (R. at 319.) Additionally, Plaintiff enjoys television and reading. (Id.) She talks with friends on the phone, but does not spend a lot of time with them. (Id.) She actively participates in the lives of her children and grandchildren. (Id.) Plaintiff independently takes care of her hygiene and appearance. (Id.)

Dr. Goldberg diagnosed Plaintiff with dysthymic disorder, in partial remission, and panic disorder, without agoraphobia, in remission, and assigned Plaintiff a GAF of 65. (R. at 320.)

Dr. Goldberg found "no reason to think that psychiatric issues are currently significant in her decisions to work or not." (R. at 319.)

6. Dr. Cornejo

Dr. Juan C. Cornejo, D.O., completed an orthopedic consultative exam on March 14, 2012. (R. at 323-26.) Plaintiff reported suffering from fibromyalgia and back pain since 1999 and bilateral hand pain since 2003, although she did not receive orthopedic treatment for these conditions.¹ (R. at 323.) Dr. Cornejo found that Plaintiff had a "full range of motion of upper and lower extremities;" "a positive Tinel's sign on the left and right wrist;" "decreased range of motion of the cervical and lumbar spine;" "a negative supine and sitting straight leg raising maneuver test bilaterally;" and "intact fine and gross manipulation." (R. at 326.) Dr. Cornejo described Plaintiff's prognosis as fair in light of her continued complaints of pain in her hands and back despite some treatment. (Id.) "Based primarily upon her subjective reports," Dr. Cornejo found Plaintiff to be "limited from frequent overhead use of her upper extremities, frequent turning and bending of her neck and back and from repetitive heavy lifting." (Id.)

7. Dr. Acuna

¹ Plaintiff also noted hip and neck pain which went untreated.

Dr. Jose Acuna, M.D., a state agency medical consultant, completed a Physical Residual Functional Capacity Assessment form on April 23, 2012. (R. at 105.) Dr. Acuna determined that Plaintiff could lift and carry 20 pounds occasionally, ten pounds frequently, can stand and walk for six hours in an eight hour workday, sit for six hours in an eight hour workday, with an unlimited ability to push and pull. (Id.) Dr. Leonard Simpson, M.D., and Dr. Melvin Golish, M.D., two other state agency medical consultants, affirmed Dr. Acuna's opinion on May 10, 2012 and August 31, 2012 respectively. (R. at 332-33; 131-34.)

8. Dr. Joynson

On March 6, 2012, a state agency medical consultant, Joan Joynson, Ph.D., completed a Psychiatric Review Technique form. (R. at 102-03.) Dr. Joynson's March, 2012 evaluation lists fibromyalgia, carpal tunnel syndrome, as well as Plaintiff's affective and anxiety disorders as severe impairments. (R. at 102.) Dr. Joynson noted mild restrictions of activities of daily living and mild difficulties in maintaining social functioning, in addition to moderate difficulties in maintaining concentration, persistence or pace, and no repeated episodes of decompensation. (R. at 103.)

Subsequently, on June 13, 2012, Dr. Joynson completed a

second Psychiatric Review Technique form altering some of her initial determinations. (R. at 118-19.) Dr. Joynson's June, 2012 evaluation lists fibromyalgia and carpal tunnel syndrome as severe impairments and Plaintiff's affective and anxiety disorders as non-severe. (R. at 118.) Dr. Joynson noted mild restrictions of activities of daily living, mild difficulties in maintaining social functioning, mild difficulties in maintaining concentration, persistence or pace, and no repeated episodes of decompensation. (Id.) Dr. Joynson indicated that Plaintiff's mental impairments "are not severe in that she is able to engage in basic work functions, she can adequately adapt to workplace changes for basic work functions and respond appropriately to supervision." (R. at 119.) Dr. Cheryl Sanford, Ph.D., another state agency medical consultant, agreed with Dr. Joynson's opinion on August 31, 2012. (R. at 129-30.)

The Agency's Disability Determination Explanation indicates that Dr. Joynson altered her determination at the request of an agency reviewer. (R. at 115-19.) Indeed, after receiving Dr. Joynson's report, the agency issued a "Request for Corrective Action" which included the following:

A psychological CE dated 01/17/12 reports [Plaintiff] had a past history of anxiety disorder, but stated her symptoms had diminished to "once in a blue moon", no more than once a week while working. She has not sought psychiatric treatment for the disorder in some time. The claimant also reports a remote history of depression, but no symptoms presently. MSE states

some ruminative thoughts but otherwise [within normal limits]; ADLs unimpaired other than physical limitations; and a diagnosis of dysthymic disorder in partial remission and panic disorder without agoraphobia in remission. CE summary states that she finds her symptoms of both anxiety and depression have reduced significantly. DDS' MRFC assessment narrative was not written in program language detailing the most that the claimant can do despite her mental MDI. However, the evidence better documents a non-severe impairment, with no limitations in CPP.

(R. at 239.)

Dr. Joynson, in her June, 2012 assessment acknowledged that she was asked by an agency reviewer to change "this review to a 'Not severe' rating." (R. at 119.) Dr. Joynson explained that Plaintiff

has a hx of anxiety which she indeed honestly reported as improving, and she said that she had no panic attacks when she was not working. She did report having one panic attack per week while working - does this constitute a mild or moderate RFC? This appears to be a matter of judgement [sic]. Certainly, having a panic attack at work would interfere with cpp and the more complex or demanding a job, the more likely a panic attack will occur. CL also reports increasing anxiety which is documented by her PCP in 1/11. This is why I gave the clmt the benefit of the doubt, which we are encouraged to do and made the rating a moderate.

(Id.) Dr. Joynson changed her determination to "not severe," but requested that the Agency "consider cl's hx of anxiety, her honesty, and her doctor's report of increasing anxiety in 1/11."

(Id.)

C. Plaintiff's testimony

Plaintiff testified that she experienced a long history of depression and anxiety, including panic attacks "once every

couple of months.” (R. at 45, 59.) In the past, Plaintiff’s panic attacks have included chest pains, profuse sweating, and headaches. (R. at 67-68.) Plaintiff reported difficulty concentrating and focusing, as well as difficulty with her memory. (R. at 60, 65.) Plaintiff says she can watch television, but lacks the concentration to watch a movie. (R. at 61.)

According to Plaintiff’s testimony, she has also suffered from fibromyalgia, marked by throbbing pain in her hands, neck, back, and hip. (R. at 45-48.) Plaintiff reports difficulty getting out of bed on most days, as well as trouble using her hands. (R. at 49.) She experiences difficulty with buttons and her hand pain prevents her from using a keyboard. (R. at 53-54.) Plaintiff relies on her husband and daughter for household tasks such as cooking, vacuuming, and cleaning. (R. at 49-50, 75.) She occasionally drives and will accompany her husband to the store, but he does all of the lifting. (R. at 50.)

D. ALJ Decision

In a written decision dated March 25, 2014, ALJ Toland determined that Plaintiff was not disabled from July 9, 2010 through the date of decision. (R. at 29.) She found that Plaintiff had not engaged in substantial gainful activity since July 9, 2010, the alleged onset date, and concluded that she suffered from the following severe impairment: carpal tunnel

syndrome. (R. at 20.) The ALJ found that Plaintiff's combination of impairments did not meet or medically equal the severity of an impairment listed in the regulations. She described Plaintiff's residual functional capacity ("RFC") as follows:

the claimant has the residual functional capacity to perform light work as defined in 20 CFR 404.1567(b) except that the claimant can lift 20 pounds occasionally, 10 pounds frequently, but must use both hands to lift these amounts, can stand and walk for up to 6 hours per day, but no more than 1 hour at a time and then would need to sit or shift positions for 4-5 minutes every hour while remaining on task. The claimant would be off task up to 5% of the workday in addition to normal breaks and lunch, due to her symptoms.

(R. at 24.) Notably, the ALJ assigned great weight to Dr. Joynson's June, 2012 evaluation finding only mild functional limitations because such an opinion is "consistent with the objective medical evidence and the record as a whole." (R. at 28.) In contrast, the ALJ assigned little weight to Dr. Joynson's earlier evaluation finding moderate limitations in concentration, persistence or pace as it was inconsistent with Dr. Goldberg's evaluation and Plaintiff's own testimony. (Id.) Moreover, in discussing Plaintiff's history of depression and anxiety, the ALJ determined that "the claimant's statements concerning the intensity, persistence and limiting effects of these symptoms are not entirely credible for the reasons explained in this decision." (R. at 25.) The ALJ noted numerous inconsistent statements during Plaintiff's testimony. (Id.)

After determining Plaintiff's RFC, the ALJ determined that Plaintiff is capable of performing past relevant work as a medical secretary, which does not require the work-related activities precluded by Plaintiff's RFC. (R. at 29.) Accordingly, the ALJ ruled that Plaintiff was not disabled from July 9, 2010 through the date of Decision. (Id.)

III. STANDARD OF REVIEW

This Court reviews the Commissioner's decision pursuant to 42 U.S.C. § 405(g). The Court's review is deferential to the Commissioner's decision, and the Court must uphold the Commissioner's factual findings where they are supported by "substantial evidence." 42 U.S.C. § 405(g); Fargnoli v. Massanari, 247 F.3d 34, 38 (3d Cir. 2001); Cunningham v. Comm'r of Soc. Sec., 507 F. App'x 111, 114 (3d Cir. 2012). Substantial evidence is defined as "more than a mere scintilla," meaning "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Richardson v. Perales, 402 U.S. 389, 400 (1971); Hagans v. Comm'r of Soc. Sec., 694 F.3d 287, 292 (3d Cir. 2012) (using the same language as Richardson). Therefore, if the ALJ's findings of fact are supported by substantial evidence, the reviewing court is bound by those findings, whether or not it would have made the same determination. Fargnoli, 247 F.3d at 38. The Court may not weigh

the evidence or substitute its own conclusions for those of the ALJ. Chandler v. Comm'r of Soc. Sec., 667 F.3d 356, 359 (3d Cir. 2011).

IV. DISCUSSION

Plaintiff argues that the ALJ erred in failing to properly consider the opinion of state agency medical consultant, Dr. Joynson. Plaintiff also contends that the ALJ failed to properly consider Plaintiff's mental impairments in determining Plaintiff's RFC. Moreover, Plaintiff asserts that the ALJ erred in her assessment of Plaintiff's credibility. The Court will address each argument in turn.

A. The ALJ properly considered Dr. Joynson's opinion

The Court notes at the outset that when a conflict in the evidence exists, the ALJ retains significant discretion in deciding whom to credit. Plummer v. Apfel, 186 F.3d 422, 429 (3d Cir. 1999); Brown v. Astrue, 649 F.3d 193, 196 (3d Cir. 2011) (noting that "the ALJ is entitled to weigh all evidence in making its finding" and the ALJ is not required to accept the opinion of any medical expert). However, the ALJ "cannot reject evidence for no reason or for the wrong reason." Plummer, 186 F.3d at 429 (citation omitted). "The ALJ must consider all the evidence and give some reason for discounting the evidence she rejects." Id.; Johnson v. Comm'r of Soc. Sec., 529 F.3d 198, 203

(3d Cir. 2008) ("Although the ALJ may weigh the credibility of the evidence, he must give some indication of the evidence which he rejects and his reason(s) for discounting such evidence.") (quoting Burnett v. Comm'r of Soc. Sec. Admin., 220 F.3d 112, 121 (3d Cir. 2000)).

Moreover, the opinions of state agency medical consultants merit significant consideration. Chandler v. Comm'r of Soc. Sec., 667 F.3d 356, 361 (3d Cir. 2011) (citing 20 C.F.R. §§ 404.1527(f) and 416.927(f)). The ALJ is required to evaluate and discuss the weight given to state agency medical consultants in the same manner as they are required to discuss the opinions of treating medical and non-medical sources. 20 C.F.R. § 404.1527(e)(2)(ii). When determining whether an ALJ properly considered the opinion of a state agency consultant, indications that the ALJ incorporated other sources into his or her determination can be particularly probative. See Chandler, 667 F.3d at 361-62 (noting, as important, that the ALJ incorporated the opinions of a treating nurse and did not merely "rubber stamp" a state agency consultant's conclusion).

In the present action, Plaintiff contends that the ALJ failed to properly consider the opinion of state agency medical consultant, Dr. Joynson. Plaintiff takes particular issue with the fact that Dr. Joynson's March, 2012 evaluation characterized

Plaintiff's depression and anxiety as severe, but Dr. Joynson later changed this characterization to non-severe at the request of an agency quality assurance reviewer. Plaintiff emphasizes that Dr. Joynson changed her opinion at the reviewer's urging, not because of any change in the information before her or any change in Plaintiff's condition.

Plaintiff has accurately recounted Dr. Joynson's change of view, but failed to cite any authority indicating that the ALJ erred in assigning greater weight to Dr. Joynson's second evaluation than the first. The question before the Court is not whether Dr. Joynson's latter assessment is supported by substantial evidence, as Plaintiff suggests, but rather, whether the ALJ's determination is supported by substantial evidence. As such, what Plaintiff deems a "highly improper" intervention by agency personnel, is essentially an objection to the ALJ's weighing of the evidence in the record. The Court finds no error in the ALJ's exercise of discretion when considering Dr. Joynson's evaluations. The ALJ's discussion of Dr. Joynson's opinions is supported by substantial evidence.

The ALJ ascribed "great weight" to Dr. Joynson's June, 2012 opinions finding mild limitations in Plaintiff's activities of daily living, social functioning, and concentration, persistence or pace because such opinions were "consistent with the

objective medical evidence and record as a whole." (R. at 27-28.) The ALJ, likewise, assigned great weight to Dr. Joynson's opinions that Plaintiff's mental impairments "were not severe in that she is able to engage in basic work functions." (R. at 28.) Contrary to Plaintiff's assertion, the ALJ did not ignore Dr. Joynson's prior opinions. Instead, the ALJ, as required, adequately explained why she assigned little weight to certain aspects of Dr. Joynson's earlier opinions. Specifically, the ALJ stated, "Little weight is assigned to Dr. Joynson's opinion that the claimant was moderately limited in concentration, persistence or pace, as it is inconsistent with the record. In particular, Dr. Joynson's opinion is inconsistent with her revised, subsequent opinion"² and "Dr. Goldberg's evaluation

² The Court rejects Plaintiff's argument that it was improper for the ALJ to refer to Dr. Joynson's opinions as "conflicting" when, in fact, Dr. Joynson only changed her opinion as the result of allegedly "egregious overreach" by the agency reviewer. (Pl. Br. at 9.) In Plaintiff's view, Dr. Joynson reluctantly made the change as requested by the reviewer, but stood by her original assessment. This is a plausible reading of record. It is equally plausible, however, that Dr. Joynson simply viewed the characterization of Plaintiff's mental impairments as a judgment call and, in the revised evaluation, merely sought to explain her prior characterization. Indeed, Dr. Joynson specifically stated in the June, 2012 evaluation, "This appears to be a matter of judgement [sic]," and she requested that the Agency "consider cl's hx of anxiety, her honesty, and her doctor's report of increasing anxiety in 1/11." (R. at 119.) It is not for this Court upon review to decide which explanation is more plausible. It is sufficient to note that the ALJ did not err in declining to ascribe a nefarious motive to the change and in accepting the two evaluations for what they indisputably were

notes which indicated that the claimant has sufficient concentration to repeat 6 digits forward and 5 in reverse, recalled 3/3 objects immediately and after 5 minutes, was able to perform serial 7s with only 1 error, and could spell the word 'world' backwards." (Id.) Additionally, the ALJ assigned "little weight" to Dr. Joynson's opinion that Plaintiff "could sustain work for simple work functions, can adequately adapt to workplace changes for simple work, and respond appropriately to supervision." (Id.) The ALJ again explained that Dr. Joynson's opinion was inconsistent with Dr. Goldberg's evaluation notes, "which reported that the claimant had a neutral mood with normal affective range, clear sensorium, average speech pace, lucid, logical, and goal directed thought processes, had good insight and judgment," as well as Plaintiff's testimony "in which she admitted that she has not sought any psychiatric treatment since her alleged disability onset date, noting that her panic attacks occur only every few months." (Id.) Accordingly, it is clear that the ALJ found Dr. Joynson's opinion as articulated in the June, 2012 evaluation consistent with the objective medical evidence in the record and the record as a whole. The ALJ sufficiently explained why she drew the opposite conclusion as

- conflicting. As discussed, the ALJ's decision to assign greater weight to the latter evaluation is sufficiently explained and supported by substantial evidence.

to Dr. Joynson's March, 2012 evaluation. Therefore, the Court rejects Plaintiff's argument that the ALJ failed to properly evaluate and weigh Dr. Joynson's opinions.

B. The ALJ properly considered Plaintiff's impairments in determining her RFC

At step four of the sequential analysis, the ALJ considers the claimant's residual functional capacity and past relevant work. 20 C.F.R. § 404.1520. If the claimant can still perform past relevant work, the claimant is not deemed disabled. Id. If the ALJ finds that the claimant cannot perform past relevant work or the claimant does not have past relevant work, the ALJ uses the claimant's residual functional capacity at step five to decide if the claimant can perform other work in the national economy. 20 C.F.R. § 404.1545(a)(5)(ii). The residual functional capacity assessment considers how limitations regarding claimant's physical abilities, mental abilities, and any other abilities affected by his impairments may affect the claimant's ability to do work on a regular and continuing basis. 20 C.F.R. § 404.1545(b)-(d).

The ALJ must consider all relevant medical and other evidence when determining an individual's residual functional capacity and must consider limitations imposed by all of an individual's impairments, even those that are not "severe." 20 C.F.R. § 404.1545(a)(2)-(3); see also SSR 96-8P, 1996 WL 374184,

at *5 (S.S.A. July 2, 1996). Such evidence includes medical records, lay evidence, effects of symptoms, including pain that are reasonably attributed to a medically determinable impairment, descriptions and observations of limitations by the claimant and others. 20 C.F.R. § 404.1545(a)(3). Additionally, the ALJ's findings of residual functional capacity must "be accompanied by a clear and satisfactory explanation of the basis on which it rests." Fargnoli v. Massanari, 247 F.3d 34, 41 (3d Cir. 2001) (quoting Cotter v. Harris, 642 F.2d 700, 704 (3d Cir. 1981)).

Plaintiff argues that the ALJ failed to properly consider Plaintiff's anxiety, depression, and fibromyalgia in assessing Plaintiff's residual functional capacity. The Court disagrees. The ALJ clearly considered Plaintiff's anxiety and depression, which she deemed non-severe impairments at step two,³ as part of

³ Though styled as an attack on the ALJ's RFC analysis, Plaintiff appears to challenge the ALJ's determinations at step two. Plaintiff asserts that the ALJ improperly characterized her depression, anxiety, and fibromyalgia as non-severe impairments. Even if the ALJ failed to appropriately compile a comprehensive list of impairments that qualify as "severe", under-inclusion at step two constitutes harmless error. See, e.g., Salles v. Comm'r of Soc. Sec., 229 F. App'x 140, 149 n.2 (3d Cir. 2007) ("Because the ALJ found in [Plaintiff]'s favor at Step Two, even if he had erroneously concluded that some of h[is] other impairments were non-severe, any error was harmless."); Barlow v. Comm'r of Soc. Sec., Civ. 13-538, 2014 WL 1225560, at *7 (D.N.J. Mar. 24, 2014) ("[A]ny error at step two was harmless because the ALJ continued the sequential analysis."). Because the ALJ continued her analysis beyond step two, the Court need not consider whether it

her RFC determination. The ALJ discussed Plaintiff's history of depression and panic attacks, as well as Plaintiff's report that she gets nervous in rooms of people. (R. at 25.) The ALJ recognized, however, that Plaintiff admitted that she is not taking any medication for her mental health issues; that her panic attacks are less frequent than previously, occurring only once every couple of months; and that she has not sought mental health counseling since 2010. (Id.) The ALJ assigned great weight to Dr. Goldberg's opinion that there "was no reason to think that psychiatric issues were currently significant in [Plaintiff's] decision to work or not" (R. at 27), an opinion which the ALJ previously discussed at length at step two. (R. at 21-23.) Additionally, as discussed above, the ALJ devoted three paragraphs to the opinions of Dr. Joynson and explained in significant detail why she credited some of Dr. Joynson's opinions and not others. It is abundantly clear that the ALJ found Dr. Joynson's opinions characterizing Plaintiff's mental impairments as severe to be inconsistent with the other evidence

was error to omit certain other impairments. It is well-settled that the ALJ is required to consider the cumulative effect of all impairments Plaintiff suffers from, regardless of the severity for purposes of step two, in the remainder of its analysis. See 20 C.F.R. § 404.1523. As discussed below, a review of the record makes clear that the ALJ considered all of Plaintiff's alleged impairments, including those not deemed "severe" at step two, in the remainder of the analysis.

in the record, particularly Dr. Goldberg's evaluation. It is not this Court's role to re-weigh the evidence in the record. See Gantt v. Comm'r Soc. Sec., 205 F. App'x 65, 67 (3d Cir. 2006) ("[O]ur role is not to weigh the evidence; our role on review is limited to determining whether substantial evidence supports the ALJ's denial of disability benefits."). The ALJ's discussion of Plaintiff's anxiety and depression as part of the RFC determination is well-explained and supported by substantial evidence. It is thus untenable to argue that the ALJ failed to consider limitations imposed by all of an individual's impairments, even those that are not "severe," as required by SSR 96-8P.

The same is true of Plaintiff's fibromyalgia. In fact, the ALJ devoted several pages of her RFC discussion to Plaintiff's fibromyalgia and carpal tunnel syndrome. The ALJ acknowledged Plaintiff's reports of pain in her hands, shoulders, neck, and back, which occurs nearly every day. (R. at 24.) The ALJ also recounted Plaintiff's testimony that she has difficulty getting out of bed, buttoning shirts, opening jars and turning knobs, as well as pain in her legs which make it difficult to stand for long periods of time. (R. at 24-25.) In addition to discussing Plaintiff's testimony regarding these conditions, the ALJ also considered the Adult Third Party Function Report completed by

Plaintiff's husband and the reports of state orthopedic consultant, Dr. Cornejo, and Plaintiff's treating physician, Dr. Ferenz. (R. at 25-26.) The ALJ noted that despite Plaintiff's complaints of pain, Dr. Goldberg's report and Plaintiff's own testimony regarding her functional abilities were "inconsistent with a finding of disability." (R. at 26.) The ALJ highlighted Plaintiff's ability to shower independently, wash dishes, drive a car, and watch her grandson on the weekends. (Id.) Consistent with the evidence in the record, the ALJ concluded that Plaintiff could perform light work with certain limitations. (Id. ("[T]he medical record as a whole supports a conclusion that the claimant can perform light work with acknowledged limitations. The undersigned considered the effects of the claimant's carpal tunnel syndrome and fibromyalgia in assigning a light residual functional capacity with sit/stand option.")) Therefore, the ALJ's thorough written opinion belies Plaintiff's argument that she failed to consider Plaintiff's fibromyalgia in determining Plaintiff's RFC.

C. The ALJ did not err in her assessment of Plaintiff's credibility

SSR 96-7p requires the ALJ to make credibility determinations grounded in the evidence and in light of the entire case record. SSR 96-7p, 1996 WL 374186, at *1 (S.S.A. July 2, 1996). The ALJ cannot simply state that the "allegations

have been considered" or that they categorically are not credible. Id. at *2. "The determination or decision must contain specific reasons for the finding on credibility, supported by the evidence in the case record, and must be sufficiently specific to make clear to the individual and to any subsequent reviewers the weight the adjudicator gave to the individual's statements and the reasons for that weight." Id.

In the present case, the ALJ's written decision clearly indicates the weight she assigned Plaintiff's statements and the corresponding reasons. Importantly, the ALJ did not entirely disregard Plaintiff's testimony. The ALJ simply found that Plaintiff's "statements concerning the intensity, persistence and limiting effects of these symptoms" were "not entirely credible." (R. at 25.) The ALJ considered Plaintiff's testimony in concluding that she could perform light work **"with acknowledged limitations.**" (R. at 26) (emphasis added). Moreover, the ALJ explained in detail why she questioned the severity of Plaintiff's impairments. See Martin v. Comm'r of Soc. Sec., 547 F. App'x 153, 159 (3d Cir. 2013) (upholding the ALJ's credibility determination when the ALJ (1) stated the claimant's testimony was not credible because it did not comport with the weight of the evidence in the file and (2) described the contrary evidence). The ALJ identified numerous inconsistent

statements during Plaintiff's testimony. (R. at 25.) For example, Plaintiff testified that she did not like to be around crowds, yet she also testified she accompanied her husband to the mall. (Id.) Similarly, the ALJ found Plaintiff's testimony that she does not babysit her grandchildren to be inconsistent with her responses on the Function Report indicating that she watches her grandson on the weekend. (Id.) The ALJ also noted inconsistencies between her testimony and her statements to Dr. Goldberg regarding her functional limitations. (R. at 26.) Therefore, the Court finds no error in the ALJ's assessment of Plaintiff's credibility.

The Court is unpersuaded by Plaintiff's argument that it was improper for the ALJ to reject Plaintiff's testimony based on a lack of medical treatment. Plaintiff is correct that the ALJ observed that there were "little to no" treatment records regarding Plaintiff's low back pain and fibromyalgia and "essentially no evidence" that Plaintiff sought any treatment for her anxiety or depression. (R. at 21.) The ALJ later noted that a lack of health insurance prevented Plaintiff from seeking medical treatment for certain conditions, including fibromyalgia. (R. at 24.) As a result, Plaintiff argues that the ALJ has contravened SSR 96-7P which provides that "the adjudicator must not draw any inferences about an individual's

symptoms and their functional effects from a failure to seek or pursue regular medical treatment without first considering any explanations that the individual may provide, or other information in the case record, that may explain infrequent or irregular medical visits or failure to seek medical treatment." SSR 96-7P, 1996 WL 374186, at *7 (S.S.A. July 2, 1996). However, the ALJ in these statements appears only to note the lack of objective medical evidence in the record regarding Plaintiff's alleged impairments. Indeed, immediately after observing that there is only a "one sentence notation during a single office examination" to suggest that Plaintiff's anxiety was returning, the ALJ states that it is "the claimant's responsibility to provide medical evidence showing that she has an impairment, and to show how the impairment affects her functioning during the time alleged as disabled." (R. at 21.) The ALJ, in so stating at step two, was discussing whether Plaintiff's anxiety and depression could be considered severe impairments. She was not discussing Plaintiff's credibility. To the extent the ALJ did rely on a lack of medical records in determining Plaintiff's credibility, it was one of many reasons the ALJ discredited certain aspects of Plaintiff's testimony. As such, the ALJ's observation regarding the lack of treatment records was, at most, harmless error. See Rutherford v. Barnhart, 399 F.3d 546,

553 (3d Cir. 2005) ("[R]emand is not required here because it would not affect the outcome of the case.").

V. CONCLUSION

For the foregoing reasons, the Court finds that substantial evidence in the record supports the ALJ's determination that Plaintiff did not have a qualifying disability under the Social Security Act. Therefore, the Court will affirm the Commissioner's final decision. An accompanying Order will be entered.

June 22, 2015
Date

s/ Jerome B. Simandle
JEROME B. SIMANDLE
Chief U.S. District Judge